Meaningful Use Workgroup
Stage 3 Recommendations

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Workgroup Membership

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Paul Tang	Palo Alto Medical Foundation
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Neil Calman	Institute for Family Health
Tim Cromwell	Department of Veterans Affairs
Art Davidson	Denver Public Health
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James Figge	NY State Dept. of Health
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Leslie Kelly Hall	Healthwise
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Greg Pace	Social Security Administration
Robert Tagalicod	CMS/HHS
Karen Trudel	CMS
Charlene Underwood	Siemens
Amy Zimmerman	Rhode Island Department of Health and Human Services

HITPC Stage 3 MU Timeline

- **Oct, 2012 – present pre-RFC preliminary stage 3 recs**
- Nov, 2012 – RFC distributed
- Dec 21, 2012 – RFC deadline
- Jan, 2013 – ONC synthesizes RFC comments for WGs review
- Feb, 2013 – WGs reconcile RFC comments
- **Mar, 2013 – present revised draft stage 3 recs**
- **Apr, 2013 – approve final stage 3 recs**
- May, 2013 – transmit final stage 3 recommendations to HHS

Guiding Principles

- **Supports new model of care** (e.g., team-based, outcomes-oriented, population management)
- Addresses **national health priorities** (e.g., NQS, Million Hearts)
- **Broad applicability** (since MU is a floor)
  - Provider specialties (e.g., primary care, specialty care)
  - Patient health needs
  - Areas of the country
- Promotes **advancement** -- Not "topped out" or not already driven by market forces
- **Achievable** -- mature standards widely adopted or could be widely adopted by 2016
- **Reasonableness/feasibility** of products or organizational capacity
  - Prefer to have standards available if not widely adopted
  - Don’t want standards to be an excuse for not moving forward

Key to reviewing items

- ***Red items - changes from Stage 1 to Stage 2***
- Blue items - changes from Stage 2 to Stage 3 recommendations
- *Green items - updates made following the August 1, 2012 HITPC*

Improve Quality Safety, Efficiency and Reducing Health Disparities - Subgroup 1

Improve Quality Safety, Efficiency and Reducing Health Disparities

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4 Placeholder
SGRP 101	**Medication only:** More than 30% of unique patients seen during the reporting period with at least one medication in their medication list have at least one medication order entered using CPOE	**EP Objective:** Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines **EH Objective:** Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines **EP/EH Measure:** More than ***60 percent of medication, 30 percent of laboratory, and 30 percent of radiology orders*** created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) ***during the EHR reporting period are recorded using CPOE. ***	**Objective:** Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines to create the first record of the order. *CPOE for medications includes DDI checking for "never" combinations as determined by an externally vetted list.* **Measure:** More than 60% of medication, laboratory, and radiology orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE ***Certification Criteria:*** *EHR must be able to consume an externally supplied list of "never" DDIs, using RxNorm and NDF-RT standards along with a TBD DDI reactions value set.* *Certification Only for EPs* *•EHRs must also have the ability to identify abnormal test results and track when results are available.* *•EHR must have the ability to transmit lab orders using the lab order and results Interface guidelines produced by the S&I Framework Initiative.* ***RFC****: Are the existing standards for laboratory orders adequate to support including this certification criterion?*	*Seeking externally maintained list of DDIs with higher predictive value*

Improve Quality Safety, Efficiency and Reducing Health Disparities

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4 Placeholder
SGRP 130	New for stage 3	New for stage 3	**Objective:** Use computerized provider order entry for referrals/transition of care orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines to create the first record of the order. **Measure:** More than **20%** of referrals/transition of care orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded.	

Improve Quality Safety, Efficiency and Reducing Health Disparities

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4 Placeholder
SGRP 103	**EP only:** Generate and transmit more than 40% of all permissible prescriptions electronically	**EP Objective:** Generate and transmit permissible prescriptions electronically (eRx) **EP Measure:** More than ***50%*** of all permissible, or all permissible and non permissible, prescriptions written by the EP and queried for a drug formulary and transmitted electronically using CEHRT. **EH *MENU* Objective:** Generate and transmit permissible discharge prescriptions electronically (eRx) **EH *MENU* Measure:** More than ***10%*** of hospital discharge medication orders for permissible prescriptions (for new, changed, and refilled prescriptions) are queried for a drug formulary and transmitted electronically using Certified EHR Technology	**EP Objective:** Generate and transmit permissible prescriptions electronically (eRx) **EP Measure:** More than 50% of all permissible prescriptions written by the EP are compared to at least one drug formulary (reviewed for generic substitutions) transmitted electronically using Certified EHR Technology. **EH Objective:** Generate and transmit permissible discharge prescriptions electronically (eRx) **EH Measure:** More than 30% of hospital discharge medication orders for permissible prescriptions (for new or changed prescriptions) are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology	*RFC: How to include formulary checking into EHR and connection to formulary sources (e.g., PBMs)?* ***IE Recommendation**: Advanced medication reconciliation to check for formulary compliance.* *Medication formulary checking:* *If Rx is formulary-compliant, transmit to pharmacy.* *If Rx is not formulary compliant, prescriber presented with alternatives (if available through formulary database) or provided a structured prior-authorization form to complete before Rx transmitted. Capability for automatic approval of prior-auth should be available.*

Improve Quality Safety, Efficiency and Reducing Health Disparities

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4 Placeholder

SGRP 104	**Record demographics as structured data for more than 50% of all unique patients:**
	• Preferred language
	• Gender
	• Race
	• Ethnicity
	• Date of birth
	
	(Hospital Only) date and preliminary cause of death in the event of mortality in the eligible hospital or CAH
		EP Objective: Record the following demographics
		• Preferred language
		• ***Sex***
		• Race
		• Ethnicity
		• Date of birth
		
		EH Objective: Record the following demographics
		• Preferred language
		• ***Sex***
		• Race
		• Ethnicity
		• Date of birth
		• Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH
		
		Measure: More than ***80 percent of all unique patients*** seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data
			Remove objective because topped out and ensure used in CQMs for disparities.
			
			Certification criteria:
			• *Occupation and industry codes*
			• *Sexual orientation, gender identity (optional fields)*
			• *Disability status*
			  • *Differentiate between patient reported & medically determined*
			  • *Need to continue standards work*	

Improve Quality Safety, Efficiency and Reducing Health Disparities

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4 Placeholder
SGRP 105	**Maintain an up-to-date problem list of current and active diagnoses for more than 80% of all unique patients:** have at least one entry or an indication that no problems are known for patient recorded as structured data	***Consolidated with summary of care***	**New for stage 3** **Certification criteria only:** EHR systems should provide functionality to help maintain up-to-date, accurate problem list **Certification criteria only:** *Use of lab test results, medications, and vital signs (BP, ht, wt, BMI), to support clinicians' maintenance of up-to-date accurate problem lists. Vendors utilize rules to help providers improve the problem list (e.g. Method for Assigning Priority Levels). System provides prompts about additions, edits, and deletions for clinicians review and action.* *RFC: How to incorporate into certification criteria for pilot testing?*	**Stage 4:** Patient input to reconciliation of problems
SGRP 106	**Maintain active medication list:** more than 80% of all unique patients have at least one entry recorded as structured data (or indication that the patient is on no meds)	***Consolidated with summary of care***	**New for Stage 3** **Certification criteria only:** EHR systems should provide functionality to help maintain up-to-date, accurate medication list Use of problems and lab test results to support clinicians' maintenance of up-to-date accurate medication lists by clinicians. *System provides prompts about additions, edits, and deletions for clinicians review.* *RFC: How to incorporate into certification criteria for pilot testing?*	**Certification criteria:** Use other EHR data such as medications filled or dispensed, or free text searching for medications to support maintenance of up-to-date and accurate medication lists.
SGRP 107	**Maintain active medication allergy list:** More than 80% of all unique patients seen during the reporting period have at least one entry (or indication that the patient has no known medication allergies) recorded as structured data	***Consolidated with summary of care***	**New for stage 3** **Certification criteria only:** EHR systems should provide functionality to code medication allergies and link to related drug family, and code related reaction. *System provides prompts about additions, edits, and deletions for clinicians review and action.*	**Stage 4:** Contraindications that could include: adverse reactions, procedural intolerance.

Improve Quality Safety, Efficiency and Reducing Health Disparities

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4 Placeholder
SGRP 108	**Record and chart changes in vital signs:** more than 50% of all unique patients age 2 and over have vital signs recorded as structured data • Height • Weight • Blood pressure • Calculate and display BMI • Plot and display growth charts for children 2-20 years, including BMI	**Objective: Record and chart changes in vital signs:** • Height/length • Weight • Blood pressure *** (age 3 and over) *** • Calculate and display BMI • Plot and display growth charts for patients 0-20 years, including BMI **Measure:** More than ***80%*** of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have blood pressure (for patients age 3 and over only) and height/length and weight (for all ages) recorded as structured data	Retire as topped out measure?	
SGRP 109	**Record smoking status** for patients 13 years old and older: more than 50% of all unique patients seen during the reporting period 13 years or older have smoking status recorded as structured data	**EP/EH Objective:** Record smoking status for patients 13 years old or older **Measure:** More than ***80%*** of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data	Retire and incorporate into CQM?	

Improve Quality Safety, Efficiency and Reducing Health Disparities

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4 Placeholder
SGRP 112	**EH MENU:** Record whether an advance directives for more than 50% patients 65 years old or older	**EH MENU Objective:** Record whether a patient 65 years old or older has an advance directive **EH MENU Measure:** More than 50 percent of all unique patients 65 years old or older ***admitted to the eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data.***	Ensure standards support in CDA by 2016 EP MENU/EH Core **Objective:** Record whether a patient 65 years old or older has an advance directive EP MENU/EH Core **Measure:** More than 50 percent of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data.	

Improve Quality Safety, Efficiency and Reducing Health Disparities

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4 Placeholder
SGRP 113	**EP:** Implement one clinical decision support rule relevant to specialty or high clinical priority along with ability to track compliance with that rule **EH:** Implement one clinical decision support rule related to a high priority hospital condition along with the ability to track compliance with that rule	**EP/EH Objective:** Use clinical decision support to improve performance on high-priority health conditions **Measure:** 1. Implement ***five clinical decision support interventions related to four or more clinical quality measures. Absent four**** clinical quality measures are related to an EP's scope of practice, the provider may select clinical decision support interventions ***at a relevant point in patient care related to high-priority health conditions**** for the entire EHR reporting period. It is suggested that ***one of the five**** clinical decision support interventions ***be related to improving healthcare efficiency. **** 2. The EP, eligible hospital or CAH has enabled and ***implemented the functionality for drug-drug and drug-allergy interaction**** checks for the entre EHR reporting period.	**Objective:** Use clinical decision support to improve performance on high priority health conditions **Measure:** 1. Implement 15 clinical decision support interventions ~~related to five or more clinical quality measures~~ that are presented at a relevant point in patient care for the entire EHR reporting period. The 15 CDS interventions should include one or more interventions in each of the following areas, as applicable to the EP's specialty: • **Preventative care** (including immunizations) • **Chronic disease management** (e.g., diabetes, hypertension, coronary artery disease) • Appropriateness of **lab and radiology orders** • Advanced medication-related decision support* (e.g., renal drug dosing) 2. The EP, eligible hospital, or CAH has enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period. **Certification criteria only:** 1. Ability to track CDS triggers and how the provider responded ** 2. Ability to flag preference-sensitive conditions, and provide decision support materials for patients. 3. Capability to check for a maximum dose in addition to a weight based calculation. *Kuperman,GJ. (2007). Medication-related clinical decision support in computerized provider order entry systems: a review. *Journal of the American Medical Informatics Association: JAMIA, 14*(1):29-40. **this is used to improve the effectiveness of CDS interventions	Create generic ability to consume lists to support CDS interventions (e.g., rules for DDI, rules for reporting diseases for public health departments, preference-sensitive care lists)

Improve Quality Safety, Efficiency and Reducing Health Disparities

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4 Placeholder
SGRP 114	**MENU:** Incorporate clinical lab test results into certified EHR technology as structured data for more than 40% of all clinical lab tests results ordered whose results are either in a positive/negative or numerical format	**EP/EH Objective:** Incorporate clinical lab-test results into Certified EHR Technology as structured data **Measure:** More than ***55%*** of all clinical lab tests results ordered by the EP or by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23 during the EHR reporting period whose results are either in a positive/negative affirmation or numerical format are incorporated in Certified EHR Technology as structured data	**Objective:** Incorporate clinical lab-test results into EHR as structured data **Measure:** More than 80% of all clinical lab tests results ordered by the EP or by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data	
SGRP 115	**MENU:** Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach	**EP *CORE* Objective:** Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach **EP *CORE* Measure:** Generate ***at least one report*** listing patients of the EP, eligible hospital or CAH with a specific condition.	**EP Objective:** Generate lists of patients for multiple specific conditions and present near real-time (vs. retrospective reporting) patient-oriented dashboards to use for quality improvement, reduction of disparities, research, or outreach reports. Dashboards are incorporated into the EHR's clinical workflow for the care coordinator or the provider. It is actionable and not a retrospective report.	

Improve Quality Safety, Efficiency and Reducing Health Disparities

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4 Placeholder
SGRP 116	**EP MENU:** Send preventive or follow-up reminders to more than 20% of all unique patients 65+ years old or 5 years old or younger	**EP Objective:** Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminder, ***per patient preference. *** **Measure:** More than ***10%*** of all unique patients who have had two or more office visits with the EP within the 24 months before the beginning of the EHR reporting period ***were sent a reminder, per patient preference when available***	**EP Objective:** Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminder, per patient preference. **EP Measure:** More than 20% of all unique patients who have had an office visit with the EP within the 24 months prior to the beginning of the EHR reporting period were sent a reminder, per patient preference **Exclusion:** Specialists may be excluded for prevention reminders (could be more condition specific).	
SGRP 117	**N/A**	**EH Objective: *Automatically track medications*** from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR) ***Measure: More than 10% of medication orders*** created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period ***are tracked using eMAR.***	**EH Objective:** Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR) **Measure:** 1. More than 30% of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are tracked using eMAR. 2. *Mismatches (situations in which a provider dispenses a medication and/or dosing that is not intended) are tracked and used for quality improvement.*	

Improve Quality Safety, Efficiency and Reducing Health Disparities

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4 Placeholder
SGRP 118	**N/A**	***MENU* Objective: *Imaging results*** consisting of the image itself and any explanation or other accompanying information ***are accessible through Certified EHR Technology. *** ***MENU* Measure:** More than ***10 percent of all tests whose result is an image*** ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 and 23) during the EHR reporting period ***are accessible through Certified EHR Technology***	**CORE Objective:** Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through Certified EHR Technology. **CORE Measure:** More than 10 percent of all tests whose result is an image ***(including ECGs)*** ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 and 23) during the EHR reporting period are accessible through Certified EHR Technology RFC: What barriers could be encountered in moving this to core?	
SGRP 119	**N/A**	***MENU* Objective: *Record patient family health history as structured data*** ***MENU* Measure:** More than *20 percent* of all unique patients seen by the EP or admitted to the eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period ***have a structured data entry for one or more first-degree relatives***	**CORE Objective:** Record high priority family history data **(including colon cancer, breast, glaucoma, MI, diabetes)** **CORE Measure: Record high priority family history in 40%** of patients seen during reporting period **Certification criteria:** Make sure that every **CDS intervention can take into account family history** for outreach (need to move that functionality along as part of preventative outreach).	

Improve Quality Safety, Efficiency and Reducing Health Disparities

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4 Placeholder
SGRP 120	**N/A**	**EP/EH *MENU* Objective:** *Record electronic notes in patient records* **EP *MENU* Measure:** Enter at ***least one electronic progress note created, edited and signed*** by an eligible professional for more ***than 30 percent*** of unique patient office visits. ***Notes must be text-searchable. Non-searchable scanned notes do not qualify but this does not mean that all of the content has to be character text. Drawings and other content can be included with text notes under this measure. *** **EP *MENU* Measure:** Enter at least one electronic progress note created, edited, and signed by an authorized provider of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) for more than ***30 percent*** of unique patients admitted to the eligible hospital or CAH's inpatient or emergency department during the EHR reporting period. ***Electronic progress notes must be text-searchable. Non-searchable, scanned notes do not qualify, but this does not mean that all of the content has to be character text. Drawings and other content can be included with text notes under this measure. ***	Record electronic notes in patient records for more than 30% of office visits within four calendar days.	

Improve Quality Safety, Efficiency and Reducing Health Disparities

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4 Placeholder
SGRP 121	**N/A**	**EH *MENU* Objective: *Provide structured electronic lab results to ambulatory providers*** **EH *MENU* Measure:** Hospital labs ***send structured electronic clinical lab results*** to the ordering provider for ***more than 20 percent*** of electronic lab orders received	**Hospital Objective:** Provide structured electronic lab results to eligible professionals. **Hospital Measure:** Hospital labs send (directly or indirectly) structured electronic clinical lab results to the ordering provider for more than 80% of electronic lab orders received.	

Engaging Patients and Families – Subgroup 2

Engage Patients and Families

ID	Stage 1 FR	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4
SGRP 204A	**N/A**	**EP Objective:** Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP. **EP Measure:** 1. More than 50% of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information 2. More than 5% of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download , or transmit to a third party their health information **EH Objective:** Provide patients the ability to view online, download, and transmit information about a hospital admission **EH Measure:** 1. More than 50% of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge 2. More than 5% of all patients (or their authorized representatives) who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH view, download or transmit to a third party their information during the reporting period	• EPs should make info available within 24 hours if generated during course of visit • For labs or other types of info not generated within course of visit, it is made available to pts within four business days of info becoming available to EPs • Signal potential for increasing both thresholds (% offer and % use) based on experience in Stage 2 **Note:** Depending on experience in Stage 2, CMS may want to give credit to some providers for view/download/transmit where the patient has specified that they prefer info to be sent to a location they specify (such as provider portal or PHR), rather than only making available information on the provider's portal. ***MENU item: Automated Transmit: (builds on "Automated Blue Button Project")*:** Provide 50% of patients the ability to designate to whom and when (i.e. pre-set automated & on-demand) a summary of care document is sent to patient-identified care team members. *Before issue final recommendations in May, will review the result of Automated Blue Button pilots.*	*Building on Automated Transmit:* *1a. Create the ability for providers to review patient-transmitted information and accept updates into EHR.* *1b. Related certification criteria: Standards needed for provider directories in order to facilitate more automated transmissions per patients' designations.*

Engage Patients and Families

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4 Placeholder
SGRP 204B	New for Stage 3	New for Stage 3	*MENU: Provide 10% of patients with the ability to submit patient-generated health information to improve performance on high priority health conditions, and/or to improve patient engagement in care (e.g. patient experience, pre-visit information, patient created health goals, etc.). This could be accomplished through semi-structured questionnaires.* *Based upon feedback from HITSC this can be a MENU item.* *Need RFC language to describe the rational for this function (contributes to health outcomes improvement, QI goals and care efficiency).*	
SGRP 204D	New for Stage 3	New for Stage 3	Objective: Offer 10% of patients the ability to amend information (e.g., offer correction, addition or update to the record)	

Engage Patients and Families

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4 Placeholder
SGRP 205	Provide clinical summaries for >50% of all office visits within 3 business days	**EP Objective:** Provide clinical summaries for patients for each office visit **EP Measure:** Clinical summaries provided to patients or patient-authorized representatives ***within 1 business day*** for more than 50 percent of office visits. We clarify that the following information (or an indication that there is no information available) is required*: • Patient name. • Provider's name and office contact information. • Date and location of the visit. • Reason for the office visit. • Current problem list. • Current medication list. • Current medication allergy list. • Procedures performed during the visit. • Immunizations or medications administered during the visit. • Vital signs taken during the visit (or other recent vital signs). • Laboratory test results. • List of diagnostic tests pending. • Clinical instructions. • Future appointments. • Referrals to other providers. • Future scheduled tests. • Demographic information maintained within CEHRT (sex, race, ethnicity, date of birth, preferred language). • Smoking status • Care plan field(s), including goals and instructions. • Recommended patient decision aids (if applicable to the visit). *an EP could withhold information from the clinical summary if they believe substantial harm may arise from its disclosure through an after-visit clinical summary	*The intent is that the information provided is intended to be relevant to the office visit. Edits to the type of information required should be made accordingly.*	

Engage Patients and Families

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4 Placeholder
SGRP 206	**MENU:** Use certified EHR to identify patient-specific educational resources for >10% of all patients	**EP/EH Objective:** Use Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient **EP *CORE* Measure:** Patient specific education resources identified by CEHRT are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period **EH *CORE* Measure:** More than 10 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) are provided patient- specific education resources identified by Certified EHR Technology	*Add language support: For the top 5 non-English languages spoken nationally, provide 80% of patient-specific education materials in at least one of those languages based on EP's or EH's local population, where publically available.*	

Engage Patients and Families

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4 Placeholder
SGRP 207	**N/A**	**EP Objective:** ***Use secure electronic messaging to communicate with patients on relevant health information*** **EP Measure:** ***A secure message was sent*** using the electronic messaging function of Certified EHR Technology by more than ***5 percent*** of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period	**Measure:** More than ***10%*** of patients use secure electronic messaging to communicate with EPs	**Stage 4:** Create capacity for electronic episodes of care (telemetry devices, etc) and to do e-referrals and e-consults
SGRP 208	**N/A**	**N/A [Communication Preferences]**	***EP and EH Measure:*** *Record communication preferences for 20% of patients, based on how (e.g., the medium) patients would like to receive information for certain purposes (including appointment reminders, reminders for follow up and preventive care, referrals, after visit summaries and test results).*	

Engage Patients and Families

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4 Placeholder
SGRP 209	***New for Stage 3***	***New for stage 3***	***Explore For Certification Rule Only:*** *Capability for EHR to query research enrollment systems to identify available clinical trials.*	*No use requirements until Stage 4.*

Improving Care Coordination – Subgroup 3

Improve Care Coordination

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4 Placeholder
SGRP 302	**MENU:** Perform medication reconciliation for >50% of transitions of care in which the patient is transitioned into the care of the EP, eligible hospital, or CAH	**EP/EH *CORE* Objective:** The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation. **EP/EH *CORE* Measure:** The EP, eligible hospital or CAH performs medication reconciliation for more than ***50%*** of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23)	**EP / EH / CAH Objective:** The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform reconciliation for: • medications • medication allergies • problems **EP / EH / CAH Measure:** The EP, EH, or CAH performs reconciliation for medications for more than 50% of transitions of care, and it performs reconciliation for medication allergies, and problems for more than 10% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23). ***SC&C Recommendation:*** *Standards work needs to be done to adapt and further develop existing standards to define the nature of reactions for allergies (i.e. severity).*	Reconciliation of **contraindications** (any medical reason for not performing a particular therapy; any condition, clinical symptom, or circumstance indicating that the use of an otherwise advisable intervention in some particular line of treatment is improper, undesirable, or inappropriate) ***SC&C Recommendation:*** *Standards work needs to be done to support the valuing and coding of contraindications.*

Improve Care Coordination

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations
SGRP 303	**MENU**: Provide a summary of care record for >50% of all transitions and referrals of care	**EP *CORE* Objective:** The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides summary care record for each transition of care or referral. **EH *CORE* Objective:** The eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides summary care record for each transition of care or referral. ***CORE* Measure:** 1. The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals. **2. *The EP, eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10% of such transitions and referrals either a) electronically transmitted using CEHRT to a recipient (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network*** 3. ***An EP, eligible hospital or CAH must satisfy one of the following criteria:** **1. one (or more) successful electronic exchanges of a summary of care document as part of "measure 2" (for EPs the measure at §495.6(j)(14)(ii)(B) and for eligible hospitals and CAHs the measure at §495.6(l)(11)(ii)(B)) with a recipient who has EHR technology developed by a different EHR developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2); or** **2. conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.*** Must include the following: • An up-to-date problem list of current and active diagnoses. • An active medication list, and • An active medication allergy list. We proposed that all summary of care documents must contain the most recent and Include the following information if the provider knows it: • Patient name. • Referring or transitioning provider's name & office contact information (EP only). • Procedures. • Immunizations • Laboratory test results. • Vital signs (height, weight, blood pressure, BMI). • Smoking status. • Functional status, including activities of daily living, cognitive and disability status • Demographic information (preferred language, sex, race, ethnicity, date of birth). • Care plan field, including goals and instructions. • Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider. • Discharge instructions (Hospital Only) • Reason for referral (EP only)	**EP/ EH / CAH Objective:** EP/EH/CAH who transitions their patient to another setting of care or refers their patient to another provider of care -Provide a summary of care record for each site transition or referral when transition or referral occurs with available information **Must include the following four for transitions of site of care, and the first for referrals (with the others as clinically relevant):** 1. Concise narrative in support of care transitions (free text that captures current care synopsis and expectations for transitions and / or referral) 2. Setting-specific goals 3. Instructions for care during transition and for 48 hours afterwards 4. Care team members, including primary care provider and caregiver name, role and contact info (using DECAF) **Measure:** The EP, eligible hospital, or CAH that site transitions or refers their patient to another setting of care (including home) or provider of care provides a summary of care record for 65% of transitions of care and referrals (and at least 30% electronically). **Certification Criteria:** EHR is able to set aside a concise narrative section in the summary of care document that allows the provider to prioritize clinically relevant information such as reason for transition and/or referral. *Certification Criteria: Inclusion of data sets being defined by S&I Longitudinal Coordination of Care WG, which and are expected to complete HL7 balloting for inclusion in the C-CDA by Summer 2013:* *1. Consultation Request (Referral to a consultant or the ED)* *2. Transfer of Care (Permanent or long-term transfer to a different facility, different care team, or Home Health Agency)*

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ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4 Placeholder
SGRP 304	***New***	***New***	***New***	***EP/ EH / CAH Objective:*** *EP/ EH/CAH who transitions their patient to another site of care or refers their patient to another provider of care* ***For each transition of site of care, provide the care plan information, including the following elements as applicable:*** • *Medical diagnoses and stages* • *Functional status, including ADLs* • *Relevant social and financial information (free text)* • *Relevant environmental factors impacting patient's health (free text)* • *Most likely course of illness or condition, in broad terms (free text)* • *Cross-setting care team member list, including the primary contact from each active provider setting, including primary care, relevant specialists, and caregiver* • *The patient's long-term goal(s) for care, including time frame (not specific to setting) and initial steps toward meeting these goals* • *Specific advance care plan (POLST) and the care setting in which it was executed* ***For each referral, provide a care plan if one exists*** ***Measure:*** *The EP, eligible hospital, or CAH that transitions or refers their patient to another site of care or provider of care provides the electronic care plan information for 10% of transitions of care to receiving provider and patient/caregiver.* ***Certification Criteria:*** *Develop standards for a shared care plan, as being defined by S&I Longitudinal Coordination of Care WG. Some of the data elements in the shared care plan overlap content represented in the CDA. Adopt standards for the structured recording of other data elements, such as patient goals and related interventions.*

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ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4 Placeholder
SGRP 305	New for Stage 3	New for Stage 3	**EP / EH / CAH Objective (new):** EP/EH/CAH to whom a patient is referred acknowledges receipt of external information and provides referral results to the requesting provider, thereby ***beginning to close the loop.*** **Measure:** For 10% of patients referred during an EHR reporting period, referral results generated from the EHR are returned to the requestor (e.g. via scan, printout, fax, electronic CDA Care Summary and Consult Report). *Certification Criteria: Include data set defined by S&I Longitudinal Coordination of Care WG and expected to complete HL7 balloting for inclusion in the C-CDA by Summer 2013: Shared Care Encounter Summary (Consultation Summary, Return from the ED to the referring facility, Office Visit)*	*Continue working to close the loop with an acknowledgement of order receipt and tracking for completion.* *In addition, include standards for referral requests that require authorizations (or pre-certifications) for procedure, surgery, lab, radiology, test orders.* ***Procedure/Surgery/lab/radiology/test prior authorization v.A:*** *for those procedures/surgeries/lab/radiology/test with clear and objective prior authorization requirements and a structured data prior authorization form is available, clinician fill out the prior authorization form using structured data fields and prior authorization can be granted electronically and in real-time by the payor.* ***Procedure/Surgery/lab/radiology /test prior authorization v.B:*** *for those procedures/surgeries/lab/radiology/test, for which prior authorization is non-standardized and is highly individualized, a standardized form is created that collects from the clinician text fields answering an agreed upon set of medical necessity questions, standardized form is sent electronically to insurer for review, insurer responds with Approval/Denial (with rationale if denied) using a standardized format text document back to clinician with either approval and/or denial with rationale.*

Improve Care Coordination

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3	Stage Undetermined
SGRP 127	New	New	New	Ability to maintain an up-to-date interdisciplinary problem list inclusive of versioning in support of collaborative care
SGRP 125	New	New	New	**Medication reconciliation:** create ability to accept data feed from PBM (Retrieve external medication fill history for medication adherence monitoring)
SGRP 308	NEW	NEW	***IE workgroup recommendation (IF provider directories exist and are operational):*** ***EH OBJECTIVE:*** *The EH/CAH will send electronic notification of a significant healthcare event in a timely manner to key members of the patient's care team, such as the primary care provider, referring provider or care coordinator, with the patient's consent if required.* ***EH MEASURE:*** *For 10% of patients with a significant healthcare event (arrival at an Emergency Department (ED), admission to a hospital, admission to a long term care facility, discharge from an ED or hospital, or death) , EH/CAH will send an electronic notification to at least one key member of the patient's care team, such as the primary care provider, referring provider or care coordinator, with the patient's consent if required, within 2 hours of when the event occurs.*	

Population and Public Health – Subgroup 4

Improve Population and Public Health

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4 Placeholder
SGRP 401A	**MENU:** Perform at least one test of the capability to submit electronic data to immunization registries	**EP/EH Objective:** Capability to submit electronic data to immunization registries or immunization information systems ***except where prohibited, and in accordance with applicable law and practice*** **EP/EH Measure:** ***Successful ongoing submission*** of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period	**EP/ EH Objective (New):** Capability to receive a patient's immunization history supplied by an immunization registry or immunization information system, and to enable healthcare professionals to use structured historical immunization events in the clinical workflow, except where prohibited, and in accordance with applicable law and practice. **Measure:** Documentation of timely and successful electronic receipt by the Certified EHR Technology of vaccine history (including null results) from an immunization registry or immunization information system for 30% of patients who received immunizations from the EP/EH during the entire EHR reporting period. **Exclusion:** EPs and EHs that administer no immunizations or jurisdictions where immunization registries/immunization information systems cannot provide electronic immunization histories. **Certification criteria:** EHR is able to receive and present a standard set of structured, externally-generated, immunization history and capture the act and date of review within the EP/EH practice.	**Stage 4 EP/EH Objective:** Add submission of vaccine contraindication(s) and reason(s) for substance refusal to the current objective of successful ongoing immunization data submission to registry or immunization information systems**.**

Improve Population and Public Health

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4 Placeholder
SGRP 401B	**New for Stage 3**	**New for Stage 3**	**EP/EH Objective (New):** Capability to receive, generate or access appropriate age-, gender- and immunization history-based recommendations (including immunization events from immunization registries or immunization information systems) as applicable by local or state policy. **Measure:** Implement an immunization recommendation system that: 1) establishes baseline recommendations (e.g., Advisory Committee on Immunization Practices), and 2) allows for local/state variations. For ***10%*** of patients receiving an immunization, the EP/EH practice receives the recommendation before giving an immunization. **Exclusion:** EPs and EHs that administer no immunizations. **Certification criteria:** EHR uses a standard (e.g., national, state and/or local) rule set, plus patient age, gender, and prior immunization history to recommend administration of immunizations; capture the act and date/time of recommendation review.	

Improve Population and Public Health

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4 Placeholder
SGRP 402A	Perform at least one test of the capability to submit electronic data on reportable lab results to public health agencies and actual submission in accordance with applicable law and practice	**EH Objective:** Capability to submit electronic reportable laboratory results to public health agencies, except where prohibited, and in accordance with applicable law and practice **Measure:** ***Successful ongoing submission**** of electronic reportable laboratory results from Certified EHR Technology to public health agencies for the entire EHR reporting period as authorized.	**EH Objective (unchanged):** No change from current requirement for electronic lab reporting which generally is sent from the laboratory information system	

Improve Population and Public Health

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Undetermined
SGRP 402B	**More information from RFC - New**	**More information from RFC - New**	**More information from RFC - New**	**RFC ONLY (Stage undetermined):** **EP Objective (new):** Capability to use externally accessed or received knowledge (e.g. reporting criteria) to determine when a case report should be reported and then submit the initial report to a public health agency, except where prohibited, and in accordance with applicable law and practice. **Measure:** Attestation of submission of standardized initial case reports to public health agencies on 10% of all reportable disease or conditions during the entire EHR reporting period as authorized, and in accordance with applicable state/local law and practice. **Certification criteria:** The EHR uses external data to prompt the end-user when criteria are met for case reporting. The date and time of prompt is available for audit. Standardized (e.g., consolidated CDA) case reports are submitted to the state/local jurisdiction and the data/time of submission is available for audit

Improve Population and Public Health

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4 Placeholder
SGRP 403	Perform at least one test of the capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice	**EP *MENU* Objective:** Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice **EH Objective:** Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice **EP/EH Measure:** Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period	**No change from current requirements.**	

Improve Population and Public Health

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4 Placeholder
SGRP 404	**N/A**	**EP *MENU* Objective:** Capability to identify and report cancer cases to a public health central cancer registry, except where prohibited, and in accordance with applicable law and practice. **EP *MENU* Measure:** Successful ongoing submission of cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period	**EH/EP Objective:** Capability to electronically participate and send standardized (i.e. data elements and transport mechanisms), commonly formatted reports to a mandated jurisdictional registry (e.g., cancer, children with special needs, and/or early hearing detection and intervention) from Certified EHR to either local/state health departments, except where prohibited, and in accordance with applicable law and practice. This objective is in addition to prior requirements for submission to an immunization registry. **Measure:** Documentation of ongoing successful electronic transmission of standardized reports from the Certified EHR Technology to the jurisdictional registry. Attestation of submission for at least ***10%*** of all patients who meet registry inclusion criteria during the entire EHR reporting period as authorized, and in accordance with applicable State law and practice. **Certification criteria:** EHR is able to build and then send a standardized report (e.g., standard message format) to an external mandated registry, maintain an audit of those reports, and track total number of reports sent. **Exclusion:** where local or state health departments have no mandated registries or are incapable of receiving these standardized reports	

Improve Population and Public Health

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4 Placeholder
SGRP 405	**N/A**	**EP *MENU* Objective:** Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice. **EP *MENU* Measure:** Successful ongoing submission of specific case information from Certified EHR Technology to a specialized registry for the entire EHR reporting period	**EP Objective:** Capability to electronically submit standardized reports to an additional registry beyond any prior meaningful use requirements (e.g., immunizations, cancer, early hearing detection and intervention, and/or children with special needs). Registry examples include hypertension, diabetes, body mass index, devices, and/or other diagnoses/conditions) from the Certified EHR to a jurisdictional, professional or other aggregating resources (e.g., HIE, ACO), except where prohibited, and in accordance with applicable law and practice. **Measure:** Documentation of successful ongoing electronic transmission of standardized (e.g., consolidated CDA) reports from the Certified EHR Technology to a jurisdictional, professional or other aggregating resource. Attestation of submission for at least ***10%*** of all patients who meet registry inclusion criteria during the entire EHR reporting period as authorized, and in accordance with applicable state/local law and practice. **Certification criteria:** EHR is able to build and send a standardized message report format to an external registry, maintain an audit of those reports, and track total number of reports sent.	

Improve Population and Public Health

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Stage 4 Placeholder
SGRP 407	New for Stage 3	New for Stage 3	**EH Objective:** Capability to electronically send standardized Healthcare Associated Infection (HAI) reports to the National Healthcare Safety Network (NHSN) using a common format from the Certified EHR, except where prohibited, and in accordance with applicable law and practice. **Measure:** Documentation of successful electronic transmission of standardized healthcare acquired infection reports to the NHSN from the Certified EHR Technology. Total numeric count of HAI in the hospital and attestation of Certified EHR electronic submission of at least 20% of all reports during the entire EHR reporting period as authorized, and in accordance with applicable State law and practice. **Certification criteria:** EHR is able to sending a standard HAI message to NHSN, maintain an audit and track total number of reports sent.	

Improve Population and Public Health

ID	Stage 1 Final Rule	Stage 2 Final Rule	Stage 3 Recommendations	Undetermined
SGRP 408	**RFC ONLY**	**RFC ONLY**	**RFC ONLY**	**RFC ONLY (Stage undetermined):** **EH/EP Objective (new):** Capability to electronically send adverse event reports (e.g., vaccines, devices, EHR, drugs or biologics) to the Federal Drug Administration (FDA) and/or Centers for Disease Control and Prevention (CDC) from the Certified EHR, except where prohibited, and in accordance with applicable law and practice. **Measure:** Attestation of successful electronic transmission of standardized adverse event reports to the FDA/CDC from the Certified EHR Technology. Total numeric count (null is acceptable) of adverse event reports from the EH/EP submitted electronically during the entire EHR reporting period as authorized, and in accordance with applicable State law and practice. **Certification criteria:** EHR is able to build and send a standardized adverse event report message to FDA/CDC and maintain an audit of those reports sent to track number of reports sent